PET DENTAL SERVICES

NON-ANESTHETIC TEETH CLEANING

Medical History Checklist

CLIENT/PET INFORMATION

Owner name:

Pet name:

Pet breed/age:

Phone number:

Date of last dental: Anesthetic: Non-anesthetic:

MEDICAL/BEHAVIOR INFORMATION (PLEASE MARK ANY THAT APPLY)

☐	Heart condition/murmur	Details:
☐	Liver/kidney issues	Details:
☐	History of seizures	Details:
☐	Respiratory issues	Details:
☐	Collapsing trachea	Details:
☐	Luxating patella/knee surgery	Details:
☐	Back pain/back surgery	Details:
☐	Neck pain/neck surgery	Details:
☐	Hip pain/dysplasia/surgery	Details:
☐	Eye problems/surgery	Details:
☐	Cancer	Details:
☐	Immune system issues	Details:
☐	Thyroid issues	Details:
☐	Blood disorders	Details:
☐	Diabetes	Details:
☐	Cushing's/Addison's disease	Details:
☐	Allergies	Details:
☐	Fear biter	Details:
☐	Dog/cat aggressive	Details:
☐	Cage aggressive	Details:
☐	Other major surgeries/medical issues	Details:
☐	Medications	Details:

Owner's Signature:____ **Date:**________________

We take the utmost pride in caring for your pet during their dental cleaning. We appreciate you taking the time to note any medical and behavioral issues that may apply and providing as much detail as you are able. Thank you.